	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) MOLTIFLE C		COMPLETED	
ANDILAN	OF CORRECTION	155512	A. BUILDING	01	05/17/2012	
		195912	B. WING		05/17/2012	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
DD 0) /E/		T.1.014F		MAIN ST		
PROVE	NA SACRED HEAR	I HOME	AVILLA	A, IN 46710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
K0000						
		l B viti vi	K0000	Submission of this plan of		
	A Life Safety Code Recertification		Roood	correction and credible allega	tion	
		nsure Survey was		of compliance does not constitute		
	conducted by t	the Indiana State		an admission by the certified	and	
	Department of	Health in		licensed provider at Provena		
	accordance wit	th 42 CFR 483.70(a).		Sacred Heart Home that the		
				allegations contained in the survey report are a true and		
	Survey Date: 0	05/17/12		accurate portrayal of the prov	ision	
				of nursing care and services a		
	Facility Number: 000404			this health care facility. Prove	ena	
	Provider Numb			Sacred Heart Home, as a licensed and certified provider	_	
	AIM Number:			recognizes its obligation to	,	
	7			provide legally and medically		
	Surveyor: Amy	/ Kelley, Life Safety		required care and services to		
	Code Specialis			residents in an economic and		
	Code Specialis	· ·		efficient fashion. Please acce this plan of correction as our	:pt	
	A++ -:- :f- C-f	into Codo como		written credible allegation of		
		ety Code survey,		compliance.		
		d Heart Home was				
		ompliance with				
	I -	for Participation in				
	Medicare/Med	icaid, 42 CFR				
	Subpart 483.7	0(a), Life Safety				
	from Fire and	the 2000 edition of				
	the National Fi	re Protection				
	Association (N	FPA) 101, Life Safety				
	Code (LSC) and	d 410 IAC 16.2. The				
	orginal buildin	g consisting of the				
	1 -	t. Claire, St. Paul,				
	and the St. Frances neighborhood					
		main dining room,				
	chapel and ser	-				
	I -	Chapter 19, Existing				
	I surveyed willi	Chapter 13, Existing	1	1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000404

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155512	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM 05/	TE SURVEY MPLETED 17/2012
	PROVIDER OR SUPPLIER NA SACRED HEART HOME	515 N N	ADDRESS, CITY, STATE, ZIP (MAIN ST ., IN 46710	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 133 and had a census of 122 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/22/12. This facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 2 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155512	B. WIN			05/17/	2012
			1	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			515 N	MAIN ST		
PROVEN	A SACRED HEART	HOME		AVILL	A, IN 46710		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0014 SS=C	Interior finish for including expose buildings such as partitions, column spread rating of 19.3.3.1, 19.3.3.2 Based on observinterview, the farmer spread rating flame spread ratinish materials exit access for the facility. The could affect all those on H hall those on H hall findings includ Based on observing the tour to 3:20 p.m., can the bottom corridor walls woof the H hall. Be interview with the during the exit p.m., document to demonstrate Class I fire spread rating the	vation and acility failed to entation for the ating of interior installed within 8 of 9 corridors in is deficient practice occupants except . e: vations with the ger on 05/17/12 from 12:45 p.m. arpet was installed one third of all with the exception	K00	014	Carpeting on the bottom third all corridor walls with the exception of the H hall has be treated by a chemical to provi Class A or Class B flame spre rating. Property Manager will retain the documentation of the chemical used and the Class flame rating for the carpeting. Property Manager is responsi Property Manager will monitor.	en de a ead ne	06/15/2012
	a. a.e rroper	-,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 3 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155512	(X2) MULTIPLE CO A. BUILDING B. WING	01	05/17	LETED 1/2012
	PROVIDER OR SUPPLIEF		515 N I	ADDRESS, CITY, STATE, ZĪ MAIN ST a, IN 46710	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	time, he has no with a chemica	ot treated the carpet I to provide a Class me spread rating.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 4 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512		A. BUII	LDING	ONSTRUCTION 01	(X3) DATE S COMPL 05/17/	ETED	
NAME OF B	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/1//	2012
	IA SACRED HEART				MAIN ST ., IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
SS=E	LIFE SAFETY C Doors protecting than required en- exits, or hazardo doors, such as the solid-bonded cor resisting fire for a sprinklered build resist the passage impediment to the Doors are provid keeping the door meeting 19.3.6.3 Roller latches are regulations in all Based on obser interview, the f ensure 2 of 2 c corridor doors treatment room closed and latce frame. This de could affect and St. Paul and St. closets and the room in the ever emergency. Findings include Based on obser Property Manage during the tour to 3:20 p.m., the	acility failed to lean linen closet and 1 of 1 n corridor doors hed into the door ficient practice y residents near the Clair clean linen St. Clair treatment ent of an le: evations with the ger on 05/17/12 from 12:03 p.m.	K00	018	Installed latching mechanisms door latches into door frame for corridor clean linen closet doo on St. Paul & St. Clare and the Clare treatment room corridor door. Maintenance to monitor weekly for compliance, see Neighborhood Environmental Checklist form "Corridor dors latch, self-closing devices operating" included and monitored by quality assurance on-gong on a monthly basis. Property Manager is responsi Property Manager will monitored by the control of the control	or ors e St. ee The ble.	06/15/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 5 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155512	(X2) MULTIPLE CC A. BUILDING B. WING	01	_	
	PROVIDER OR SUPPLIER IA SACRED HEART HOME	515 N N	ADDRESS, CITY, STATE, ZIP MAIN ST ., IN 46710	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	hardware and failed to latch into the door frame: the St. Paul and St. Clair clean linen closets and the St. Clair treatment room. This was acknowledged by the Property Manager at the time of observation. 3.1–19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 6 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	01	COMPL	ETED
		155512	B. WIN			05/17/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			515 N N	MAIN ST		
PROVEN	A SACRED HEART	ГНОМЕ			, IN 46710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0044	NFPA 101						
SS=E							
		if used, are in accordance 2.2.5					
	Based on obser	vation and	K00)44	Latching mechanisms installed		06/15/2012
	interview, the f	acility failed to			on both sets of fire doors leadi into the assisted living from the	•	
	ensure 2 of 2 fi	ire door sets were			SNF so doors latch into the fra		
	arranged to aut	tomatically close			when fire alarm is activated.		
	-	19.2.2.5 requires			Maintenance to monitor quarte	•	
	horizontal exits	•			1 time per shift and on-going a added to Fire Alarm/Fire Drill	IS	
	accordance wit	h 7.2.4 and			Report form Section II. Life		
		res fire doors to be			Safety #5 "Did the Fire Doors		
		automatic closing			close and latch into door frame?"		
	_	with 7.2.1.8. In			see form included. Property		
					Manager is responsible. Prop	erty	
		80, Standard for			Manager to monitor.		
	Fire Doors and						
	2–1.4.1 require	-					
		nall be adjusted to					
		esistance of the					
	latch mechanis	m so positive					
	latching is achi	eved on each door					
	operation. This	s deficient practice					
	could affect an	y residents near					
	doors leading t	o assisted living					
	from health car						
	Findings includ	le:					
	Based on obser	vation with the					
	Property Manag	ger on 05/17/12 at					
	3:20 p.m., both	n sets of fire doors					
	leading into the	e assisted living					
	•	re did not latch into					
		the fire alarm was					
	The frame wild	. a.c me diami was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 7 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155512	A. BUILDING	01	COMPLETED 05/17/2012
		100012	B. WING	ADDRESS CITY STATE ZIR CORE	03/11/2012
NAME OF P	PROVIDER OR SUPPLIEF	t .		ADDRESS, CITY, STATE, ZIP CODE MAIN ST	
	IA SACRED HEAR		AVILLA	A, IN 46710	
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
	activated. Base with the Proper time of observationally latch will only latch will be will not will not will be will not will not will be will not			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE
			1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ILTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155512	B. WING			05/17/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			515 N N	MAIN ST		
PROVEN	IA SACRED HEART	ГНОМЕ		AVILLA	, IN 46710		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0052	NFPA 101	ODE STANDARD					
SS=F		em required for life safety is					
		and maintained in					
		NFPA 70 National Electrical					
	Code and NFPA	72. The system has an					
		enance and testing program					
	complying with a NFPA 70 and 72	pplicable requirements of					
			K00	52	Eiro alarm appunciator panel		06/15/2012
	Based on obser		KUU	<i>54</i>	Fire alarm annunciator panel installed in the St. Anthony		00/13/2012
	interview, the f	•			Neighborhood Nursing Station		
		nd maintain 1 of 1			area that is manned 24/7.		
	fire alarm syste	ems in accordance			In-service training is provided		
	with NFPA 72,	the National Fire			nursing staff about proper action and responses to fire alarm page 1		
	Alarm Code. N	FPA 72, 1-5.4.6			notifications. Maintenance will		
	requires trouble	e signals to be			monitor on a quarterly basis, 1		
	located in an ai	rea where it is likely			time per shift for proper operat		
	to be heard. N	FPA 72, 1-5.4.4			of annunciator panel, added to		
		arms, supervisory			fire alarm/ Fire Drill Report form 10 in Section II Life Safety "Did		
	-	ouble signals to be			Annunciator Panel activate?"		
	distinctive and				#10 in Section IV Staff		
	annunciated. T				Knowledge Questions "Is staff		
		affect all residents,			aware of Annunciator Panel?"		
	staff and visito				See form included. Property Manager is responsible. Prop	ortv	
	Stair and visitor	15.			Manager to monitor.	city	
	Cincalinara in al II	la.					
	Findings includ	ie:					
	Based on an ob	servation with the					
	Maintenance Su	upervisor on					
		12 p.m., the main					
	· · ·	I is located in the					
	electrical/mech						
	· · · · · · · · · · · · · · · · · · ·	service hall which					
	was not continu						
	therefore a trot	uble signal could					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **W56121**

Facility ID: 000404

If continuation sheet Page 9 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155512		LDING	OSTRUCTION 01	(X3) DATE COMPL 05/17/	ETED
NAME OF I	PROVIDER OR SUPPLIEF		_		ADDRESS, CITY, STATE, ZIP CODE		
PROVEN	IA SACRED HEAR	Т НОМЕ			//AIN ST , IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	times. The fac an annunciator alarm system. interview with Supervisor at t	the Maintenance he time of he service hall is not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 10 of 21

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512				LDING	ONSTRUCTION 01	(X3) DATE : COMPL 05/17/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	515 N N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST ., IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0056 SS=E	If there is an autoinstalled in accordance with Sprinkler system 4 of 4 electrica accordance with Sprinkler System Complete cover of the building Sprinklers shall where all of the conditions are is dedicated to equipment is ir fire rated enclose.	eservation and acility failed to the automatic of was provided for a life rooms in the NFPA 13, the life rooms in the NFPA 13, the life rooms in the required in the room in the room in the room in the life	K00	056	All combustible items removed from all electrical rooms, no combustible storage permitted of 5-24-12. Maintenance to monitor weekly for complaince see Neighborhood Environme Checklist Electrical Rooms: "service panel unobstructed, rombustible items" form incluand monitored by quality assurance on-going on a monbasis. Property Manager responsible. Self closing devictinstalled on the corridor door to St. Clare north exit electrical room. Maintenance to monito weekly for compliance, see Neighborhood environmental checklist, monitored by quality assurance on-going on a monbasis. Property Manager responsible. 2 of 7 sprinkler heads in HR office, 2 of 19 sprinkler heads in the St. Paul dining room and 2 of 19 sprinkleds in St. Paul lounge will	ntal no ded thly e o thly	06/15/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 11 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	01	COMPLETED
		155512	B. WIN			05/17/2012
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			515 N N	MAIN ST	
	IA SACRED HEAR				, IN 46710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
TAG		·		TAG	be relocated by 6-15-12 to be	DATE
	permitted to be				separated by at least 6 feet.	
	room. This def	•			Upon further inspection to prev	vent ent
		y residents near the			other residents from having the	e
		s located in the St.			potential to be affected by the	
	Clair, St. Paul a	•			same deficient practice 21 sprinkler heads through out	
	neighborhoods	and in the St. Clair			the building will be relocated to	
	north exit area				separated by at least 6 feet by	
					6-15-2012. Property Manager	
	Findings includ	le:			responsible. Property Manage	
					will monitor. The sprinkler syst will be extended to provide	em
	Based on an ob	servations with the			sprinkler coverage to the servi	ce
	Property Manad	ger on 05/17/12			hall housekeeping chemical	
	'	to 2:35 p.m., the			storage room by	201
	· ·	rical rooms within a			6-15-12. Property Manaager warrange for sprinkler coverage	
	_	ated enclosure are			work to be performed and	
		and each electrical			supervise. Property Manager	is
	<u>-</u>	air, St. Paul and St.			responsbile. Property Manage	er
		ng used to store a			will monitor.	
		biohazardous waste				
	and a large pla					
	_	half cubic yard, full				
	of trash. The S	•				
		had a one quart				
		ainer of charcoal				
	_	Additionally, the				
	_	vice on the corridor				
		Clair north exit				
		had been removed				
	and the door d	id not self close.				
	3.1-19(b)					
	2. Based on ob	oservation and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 12 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512		LDING	NSTRUCTION 01	(X3) DATE COMPL 05/17	LETED	
	PROVIDER OR SUPPLIER		 515 N M	ADDRESS, CITY, STATE, ZIP CODE AAIN ST , IN 46710	•	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	interview, the fine ensure 2 of 7 sthe Human Res 19 sprinkler hedining room are heads in the St separated by NF Section 5–6.3.4 sprinklers be lot than six feet many resident in room and the St any staff in the office in the even emergency. Findings include Based on obsert Property Manage from 12:45 p.m. the following with the sprinkler heads in the Human the two sprinkler weight scales with the west side dining room had the west side din room had the west side dining room had the	acility failed to prinkler heads in ources office, 2 of ads in the St. Paul id 2 of 19 sprinkler . Paul Lounge were t least six feet as PA 13. NFPA 13 I requires ocated no closer easured on center. oractice could affect the St. Paul dining it. Paul lounge and Human Resource ent of a fire e: evations with the ger on 05/17/12 in. and 1:50 p.m., ivas noted regarding eads: in Resource office, er heads above the ivere located sixty				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 13 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	01	COMPLETED	
155512			B. WIN	G		05/17/2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE	
					MAIN ST	
PROVENA SACRED HEART HOME				AVILLA	, IN 46710	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
		e of the St. Paul				
	_	sprinkler heads				
	_ ·	ight inches apart.				
		owledged by the				
	' '	ger at the time of				
		Measurements were				
	provided by the	e Property Manager				
	at the time of c	observations.				
	3.1-19(b)					
	3. Based on ob	oservation and				
	interview, the f	acility failed to				
	ensure comple	te coverage was				
	provided for 1	of 1 housekeeping				
	chemical storag	ge rooms in the				
	service hall in a	accordance with				
	NFPA 13, Stand	lard for the				
	Installation of S	Sprinkler Systems,				
		plete coverage for				
	· ·	the building. This				
		ce could affect any				
	•	ated through the				
	service hall.					
	 Findings includ	le:				
		. 😅 .				
	Rased on an ob	servation with the				
		ger on 05/17/12 at				
	2:55 p.m., the					
		chemical storage				
	·	orinkler coverage.				
	i inis was ackno	owledged by the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 14 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155512	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM	TE SURVEY MPLETED 17/2012		
	PROVIDER OR SUPPLIER NA SACRED HEART HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	Property Manager at the time of observations.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 15 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512		(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION 01	(X3) DATE COMPL 05/17/	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE MAIN ST IN 46710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0144 SS=F	Generators are in exercised under month in accorda 3.4.4.1. Based on recordinterview, the form provide the cordocumentation emergency generates and power to the ensystems. NFPA 3-4.1.1.8 states shall have suffipick up the load minimum frequestability requires emergency systems. This deaffects all occure existing portions. Findings include Based on review log titled "Week Generator Log" Manager on 05 a.m., the emergwas tested monat least 30 min	acility failed to mplete for testing 1 of 1 erators providing mergency lighting 99, Section s the generator set cient capacity to d and meet the lency and voltage ements of the tem within 10 loss of normal eficient practice pants in the lens of the building. e: w of the generator	K01	44	Weekly Checks for Generator Log form will include the mont load test time for the transfer power from the main source to the generator. Property Mana will retain documentation of generator testing, Q/A to revie monthly and on-going to confiload test for transfer of power from the main source to the generator. The Property Manager is responsible. Prop Manager to monitor.	thly of o ager ew rm	06/15/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet

Page 16 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155512	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	TE SURVEY IPLETED 17/2012
	PROVIDER OR SUPPLIER		515 N N	ADDRESS, CITY, STATE, Z MAIN ST a, IN 46710	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO 1 DEFICIENC'	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	power from the generator since	e for the transfer of e main source to the e November 2011. owledged by the ger.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **W56121**

Facility ID: 000404

If continuation sheet Page 17 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 03 COMPLETE			ETED	
155512		B. WING			05/17/	2012	
NAME OF L	DDOMBED OD GUDDI IE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	.K		515 N N	MAIN ST		
	PROVENA SACRED HEART HOME			AVILLA, IN 46710			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
K0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
ROOOO							
	Δ Life Safety C	Code Recertification	K00	000	Submission of this plan of		
		nsure Survey was			correction and credible allegat		
		the Indiana State			of compliance does not constit		
	<u> </u>				an admission by the certified a	and	
	Department of				licensed provider at Provena Sacred Heart Home that the		
	accordance wi	th 42 CFR 483.70(a).			allegations contained in the survey report are a true and		
	Survey Date: (05/17/12			accurate portrayal of the provi of nursing care and services a	t	
	Facility Number	er: 000404			this health care facility. Prove	na	
	Provider Numl				Sacred Heart Home, as a		
	AIM Number:	100290810			licensed and certified provider recognizes its obligation to	,	
					provide legally and medically		
	Surveyor: Am	y Kelley, Life Safety			required care and services to	our	
	Code Specialis				residents in an economic and	. 1	
	Code Specialis				efficient fashion. Please acce this plan of correction as our	ρt	
	Δt this Life Sat	fety Code survey,			written credible allegation of		
		d Heart Home was			compliance.		
		ompliance with					
		for Participation in					
	Medicare/Med	•					
		O(a), Life Safety					
	· ·	the 2000 edition of					
	the National F						
		IFPA) 101, Life Safety					
		·					
		d 410 IAC 16.2. The					
	new section of	-					
	_	the H wing was					
	<u> </u>	Chapter 18, New					
	Health Care O	ccupancies					
	This one story	facility with a					
	partial baseme	ent was determined					

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155512		A. BUILD B. WING		03	COMPL 05/17/	ETED			
	NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST BI REGULATORY OR LSC IDENTI	E PERCEDED BY FULL		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE		
	to be of Type II (111) co and was fully sprinklere facility has a fire alarm with smoke detection in corridors, areas open to corridors and resident facility has a capacity of had a census of 122 at this survey. This facility was found compliance with the aforementioned regular requirements as evident following:	ed. The system n the o the rooms. The of 133 and the time of the not in							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 03 CO.			COMPL	ETED	
155512		B. WIN			05/17/	2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				MAIN ST		
PROVEN	IA SACRED HEART	Г НОМЕ			, IN 46710		
					., 114 407 10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144 SS=F	Generators are in exercised under month in accorda 3.4.4.1.	ODE STANDARD nspected weekly and load for 30 minutes per ance with NFPA 99.	Wal	4.4			06/15/2012
	Based on recor	d review and	K01	44	Weekly Checks for Generator	als r	06/15/2012
	interview, the f	acility failed to			Log form will include the month load test time for the transfer of	of ger	
	provide the cor	nplete			power from the main source to		
	-	for testing 1 of 1			the generator. Property Mana		
		erators providing			will retain documentation of		
		mergency lighting			generator testing, Q/A to revie		
	systems. NFPA				monthly and on-going to confir	m	
		s the generator set			load test for transfer of power from the main source to the		
					generator. The Property		
		cient capacity to			Manager is responsible. Prop	erty	
	pick up the loa				Manager to monitor.		
		iency and voltage					
	stability require						
	emergency syst						
	seconds after lo	oss of normal					
	power. This de	eficient practice					
	affects all occu	pants in the new					
	portions of the	building.					
	•	_					
	Findings includ	le:					
	Based on review	w of the generator					
	log titled "Week	<u>-</u>					
	_	with the Property					
	_	/17/12 at 11:51					
	_						
		gency generator					
		nthly under load for					
		utes, however, the					
	monthly load to	est record did not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **W56121**

Facility ID: 000404

If continuation sheet

Page 20 of 21

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PROVENA SACRED HEART HOME STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710	
515 N MAIN ST	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
include the time for the transfer of power from the main source to the generator since November 2011. This was acknowledged by the Property Manager. 3.1–19(b)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W56121

Facility ID: 000404

If continuation sheet Page 21 of 21